

**STATE OF WISCONSIN  
DEPARTMENT OF EMPLOYEE TRUST FUNDS  
INCOME CONTINUATION INSURANCE FORMS/BOOKLETS ORDER FORM**

**Employer Name:** \_\_\_\_\_ **EIN: 69-036-**\_\_\_\_\_

**Street Address:** \_\_\_\_\_  
\_\_\_\_\_

**Mailing Address:** (if different) \_\_\_\_\_  
\_\_\_\_\_

**Contact Name:** \_\_\_\_\_

**Contact Phone:** \_\_\_\_\_

**State & Local Employer Orders**

**Please indicate forms and quantity needed:**

<u>Forms/Booklets</u>	<u>Quantity</u>
<input type="checkbox"/> ET-2106 ICI Booklet – State (rev 02/2000)	_____
<input type="checkbox"/> ET-2129 ICI Booklet – Local (rev 02/2000)	_____
<input type="checkbox"/> ET-2307 ICI Enrollment Form (rev 10/99)	_____
<input type="checkbox"/> ET-2308 ICI Evidence of Insurability (EOI) Enrollment (rev 6/97)	_____
<input type="checkbox"/> ET-5106 Claim Filing Instructions for the Income Continuation Insurance and Long Term Disability Insurance Plan (8/01)	_____
<input type="checkbox"/> ET-5901 ICI Transaction Report (rev 12/2000)	_____
<input type="checkbox"/> State Claim Packet (ET-2106, ET-5350 and ET-5352)	_____
<input type="checkbox"/> Local Claim Packet (ET-2129, ET-5350 and ET-5352)	_____
<input type="checkbox"/> ET-1119 State Employers ICI Administration Manual (rev 9/88)	_____
<input type="checkbox"/> ET-1145 Local Employers ICI Administration Manual (rev 9/97)	_____

Return to: CORE Correspondence Unit	Fax: (310) 348-7126
P.O. Box 451639	Email: <a href="mailto:ICILTDI@COREINC.com">ICILTDI@COREINC.com</a>
Los Angeles CA 90045	

**Date Received at CORE:** \_\_\_\_\_

**Date Processed:** \_\_\_\_\_